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ABSTRACT

This Staff Brief was prepared for the Joint Legislative Council's Special Committee on School Health Services, which was established to study pupil health services within the public school system. Part 1 provides background information on selected federal initiatives and programs, including a joint statement on school health, and a discussion of U.S. Department of Education and U.S. Department of Health and Human Services programs. Also discussed are Wisconsin initiatives and programs relating to school health services and health education in schools, including Department of Public Instruction Programs and Activities, and Department of Health and Social Services Programs and Activities. Part 2 describes statutory and administrative rule requirements relating to the provision of school health services in Wisconsin, including the state constitution; state and federal special education requirements; immunization requirements; school district standards for emergency nursing services; school district authority to hire school nurses; administration of drugs to pupils and emergency care; and human growth and development instruction. Part 3 describes general models for delivering school health services and for the delivery of school health services in Wisconsin in particular, including methods of providing nursing services in schools. Part 4 describes various mechanisms for financing school health services, including public and private insurance. The executive summary from the 1993 Wisconsin Youth Risk Behavior Survey is appended. (DR)

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SCHOOL HEALTH SERVICES IN WISCONSIN

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Staff Brief 94-7

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Joint Legislative Council | *Madison, Wisconsin*

Special Committee on School Health Services | *September 21, 1994*

Staff Brief 94-7*

SCHOOL HEALTH SERVICES IN WISCONSIN

INTRODUCTION

This Staff Brief was prepared for the Joint Legislative Council's Special Committee on School Health Services. The Special Committee was established by a June 22, 1994 mail ballot and directed to study pupil health services within the public school system, including: (1) a review of current services and how they are provided; (2) the desirability and feasibility of modifying current health-related services and requirements; and (3) the funding of health services provided in the public schools. The Special Committee is directed to report to the Joint Legislative Council by March 1, 1995.

This Staff Brief is divided into the following parts:

Part I provides background information on selected federal and Wisconsin initiatives and programs relating to school health services and health education in schools.

Part II describes statutory and administrative rule requirements relating to the provision of school health services in Wisconsin.

Part III describes general models for delivering school health services and the delivery of school health services in Wisconsin.

Part IV describes various mechanisms for financing school health services.

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* This Staff Brief was prepared by Russ Whitesel and Pam Shannon, Senior Staff Attorneys, Legislative Council Staff.

PART I

BACKGROUND

This Part of the Staff Brief provides background information on selected federal and Wisconsin initiatives and programs regarding school health services and health education in schools. This is not intended to be an exhaustive discussion of all federal and state programs that have some relation to school health, as there are literally hundreds of programs administered by federal agencies alone that relate in some way to the health of school children.

A. FEDERAL INITIATIVES AND PROGRAMS

1. Joint Statement on School Health

On April 7, 1994, the U.S. Secretary of Education, Richard W. Riley, and the U.S. Secretary of Health and Human Services, Donna E. Shalala, issued a Joint Statement on School Health, in which they affirmed their agencies' commitment to working together cooperatively to support comprehensive school health programs.

In the Joint Statement, Secretaries Riley and Shalala noted that America's children face many compelling educational and health and developmental challenges that affect their lives and their futures:

> These challenges include poor levels of achievement; unacceptably high drop-out rates; low literacy; violence; drug abuse; preventable injuries; physical and mental illness; developmental disabilities; and sexual activity resulting in sexually transmitted diseases, including HIV, and unintended pregnancy. These facts demand a reassessment of the contributions of education and health programs in safeguarding our children's present lives and preparing them for productive, responsible, and fulfilling futures.

The Secretaries noted that school health programs support the education process, integrate services for disadvantaged and disabled children and improve children's health prospects:

> Through school health programs, children and their families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and perform well in school. These learning environments enhance safety, nutrition, and disease prevention; encourage exercise and fitness; support healthy physical, mental, and emotional development; promote abstinence and prevent sexual behaviors that result in HIV infection, other sexually transmitted diseases and unintended teenage pregnancy; discourage

use of illegal drugs, alcohol, and tobacco; and help young people develop problem-solving and decision-making skills.

In conclusion, they said that the Department of Education's GOALS 2000 Initiative and Department of Health and Human Services' HEALTHY PEOPLE 2000 Initiative provide complementary visions that, together, can support the two agencies' joint efforts in pursuit of a healthier, better-educated nation.

In furtherance of these joint efforts, the Secretaries announced the elevation, to Secretary-level status, of two committees which had previously been established at a staff level to address issues relating to providing comprehensive health services to school children. The first is the Interagency Committee on School Health, co-chaired by the Assistant Secretary for Elementary and Secondary Education in the U.S. Department of Education (DOE) and the Assistant Secretary for Health in the U.S. Department of Health and Human Services (DHHS). The Interagency Committee is comprised of representatives of a number of federal agencies and commissions which deal with issues relating to children, including but not limited to DOE, DHHS, the Departments of Agriculture, Justice and Labor and the Consumer Product Safety Commission. [It is expected that a third co-chair, the Department of Agriculture's Assistant Secretary for Nutrition and Consumer Affairs, will be added at the Committee's December 1994 meeting.] The purpose of the Interagency Committee is to increase the overall effectiveness of federal efforts to provide leadership to improve the education and health of school age children and youth through the promotion and implementation of school health programs.

The Interagency Committee has a number of subcommittees and issue-related working groups, including subcommittees on school health services and school health education. The Committee is currently studying issues relating to Medicaid reimbursement for school health services and how to provide technical assistance to states on that subject.

The second committee is the National Coordinating Committee on School Health. The Coordinating Committee is co-chaired and staffed by DOE and DHHS and its members are representatives of major national education and health organizations with an interest in school health issues, such as the American Academy of Pediatrics and the Association of Elementary and Secondary School Principals. The purpose of the National Coordinating Committee is to facilitate communication and collaboration among organizations with the ability to improve the health and educational achievement of children through school-linked and school-based programs. The Coordinating Committee coordinates its activities with the Interagency Committee on School Health.

2. U.S. Department of Education Programs

a. Comprehensive School Health Education Program

The U.S. DOE has administered a small school disease prevention and health promotion grant program known as the Comprehensive School Health Education Program (CSHEP) for a number of years. In the current federal fiscal year, $4.4 million has been distributed on a

competitive basis for three-year grants to state educational agencies, local school districts and other organizations around the country to design health education curriculum in specified categories such as nutrition and provide training for teachers in health education. The CSHEP stresses a primary prevention strategy for teaching disease prevention and health promotion life skills to school children. The CSHEP is in its final phase and it is anticipated that new grants will not be funded in the upcoming federal fiscal year. According to DOE staff, the agency's emphasis in the school health area is shifting from this so-called "categorical" approach to one in which the Secretary of Education will have more discretionary funds available to fund activities to promote comprehensive health education and the integration of education and health and social services in the schools. Wisconsin last received funds under this program in state fiscal year 1991-92.

b. Drug-Free Schools and Communities Program

This program was created as part of the Drug-Free Schools and Communities Act of 1986 and allocates funds to states for drug abuse education and prevention activities. Seventy percent of each state's funding goes to the state education agency and 30% goes to the Governor. The state education agency must allot 90% of its funds to local school districts to improve anti-drug abuse education, prevention, early intervention and rehabilitation referral programs, and the Governor must divide his or her funds among programs for high-risk youth, Drug Abuse Resistance Education (DARE) programs and other specified initiatives. Some other activities funded by the Act include training for school nurses and other school personnel on drug and alcohol abuse education and prevention, as well as counselor training grants for school nurses and other school personnel providing drug abuse prevention, counseling or referral services in schools. In state fiscal year 1993-94, the Department of Public Instruction (DPI) received $396,500 to administer the program and allocated $4,937,200 to school districts.

3. U.S. Department of Health and Human Services Programs

a. HIV Education Programs

The Division of Adolescent and School Health (DASH) of the Centers for Disease Control (CDC) and Prevention (a part of the U.S. Public Health Service in the DHHS) administers a program of fiscal support and technical assistance to enable schools and other youth-serving organizations to implement human immunodeficiency virus (HIV) education programs and integrate them into more comprehensive school health education programs. In state fiscal year 1993-94, each cooperative educational service agency (CESA) in Wisconsin received approximately $5,000 for this program.

b. State Comprehensive School Health Program Projects

In 1992, the CDC began funding demonstration projects in several states to: (1) implement or strengthen comprehensive school health education in order to prevent major health risk behaviors of school children; and (2) build infrastructure support for comprehensive school health programs by fostering collaboration between state education and state health agencies in

developing policies to support comprehensive school health programs throughout the state. The youth risk behaviors targeted in this program include tobacco use; dietary patterns that contribute to disease; sedentary lifestyle; sexual behaviors that result in HIV infection, other sexually-transmitted diseases (STD's) and unintended pregnancy; alcohol and other drug abuse; behaviors that result in unintentional or intentional injuries; and other behaviors or conditions that are leading causes of death and disability. At present, nine states, including Wisconsin, and the District of Columbia, are participating in this demonstration project. Wisconsin's program is described in Section B, 1, a, below.

c. Healthy Schools, Healthy Communities Initiative

The DHHS's Health Resources and Services Administration will be administering a $5.75 million grant program beginning on October 1, 1994, in which 30-40 grants will be awarded for school-based primary health care services, health education and promotion programs and school health staff development. For the school-based primary health care services component, grants of up to $220,000 will be awarded to community-based health providers that offer a range of primary care and health education services, serve a substantial number of underserved, homeless or at-risk children and establish a partnership with a school or school district.

For the health education and promotion component, grants of up to $65,000 will be awarded to the same types of providers as for the school-based services component and program activities must build on existing health education activities and address unmet needs of students.

For the school health staff development component, grants of up to $150,000 will be awarded to state health agencies, in collaboration with colleges or universities, to fund school health staff development in order to enhance the operation of existing school-based health centers. According to DHHS staff, some Wisconsin programs have applied for funds but the list of grant recipients will not be available until September 30, 1994.

d. School Health Policy Initiative

The DASH recently awarded a grant to Columbia University's School of Public Health for a School Health Policy Initiative to develop standards for school-based health clinics and to examine issues relating to the financing and staffing of such clinics. The Initiative also receives funding from the Carnegie Corporation.

e. Youth Risk Behavior Surveillance System

The DASH has implemented this survey system, currently used in about 40 states, to monitor trends in a number of risk behaviors among students in grades 9-12, such as substance abuse, sexual activity, violence, suicide and depression. Findings from this survey have been used to support the need for comprehensive school-based services. Information about the 1993 Wisconsin Youth Risk Behavior Survey is included in Section B, 1, b, below.

B. WISCONSIN INITIATIVES AND PROGRAMS

1. Department of Public Instruction Programs and Activities

a. Comprehensive School Health Program Initiative

In 1993, the Wisconsin DPI was awarded a federal grant of approximately $3.6 million from the CDC's State Comprehensive School Health Program for the period April 1993-November 1997, to operate a Comprehensive School Health Education Program Initiative (hereinafter, "the Program"). [The CDC's Program is described in Section A, 3, b, above.] The purpose of the Program is to strengthen comprehensive school health education and build infrastructure to support comprehensive school health programs in collaboration with the Wisconsin Department of Health and Social Services (DHSS). The funds will expand the focus of health education efforts, which in recent years has been on STD's and HIV/AIDS (Acquired Immunodeficiency Syndrome), to also include the prevention of tobacco use, sedentary lifestyles and dietary patterns that result in disease.

State-level program staff are working to integrate and coordinate categorical health education programs within DPI and DHSS to more comprehensively address these issues. Each agency has designated a project director to oversee the Program. The DPI project director is on the Student Services/Prevention and Wellness Team in the Division for Learning Support: Equity and Advocacy. The two project directors work closely together to develop statewide school health policies that support comprehensive school health programs throughout the state and to foster the collaboration between the health and education systems, focusing on the following eight components of a comprehensive school health program:

(1) **Comprehensive school health education,** consisting of sequential, grades kindergarten to 12, multidisciplinary curriculum and instruction that addresses physical, mental, emotional and social behaviors.

(2) **School health services,** promoting the health of students through prevention, case finding, early intervention and remediation of specific health problems.

(3) **A healthy school environment,** including the psychological climate and physical surroundings in which students and school personnel work.

(4) **Child nutrition services**, supporting programs that help students learn how to select nutritionally appropriate foods.

(5) **Physical education,** promoting physical fitness while maintaining cardiovascular and respiratory efficiency.

(6) **School counseling, psychology and social work,** providing broad-based prevention and intervention programs to promote the physical and emotional health of students.

(7) **School and community collaboration,** involving parents and communities to provide broad-based support and reinforcement for the objectives of a school health program.

(8) **Teacher and staff wellness**, encouraging staff to maintain and improve their health and provide strong role models for students.

b. 1993 Wisconsin Youth Risk Behavior Survey

In collaboration with the CDC, the DPI surveyed almost 6,000 Wisconsin middle and high school students in 1993 to learn about risks to their health and safety. The survey results are contained in a DPI report, 1993 Wisconsin Youth Risk Behavior Survey, dated March 1994. The survey asked questions in five areas: (1) intentional and unintentional injuries; (2) use of tobacco, alcohol and other drugs; (3) sexual activity; (4) dietary patterns; and (5) physical activity. The Executive Summary to the survey, which summarizes the survey results, is attached as an **Appendix**.

c. Collaborative Service Programs and Collaborative Projects Grants

The Collaborative Service Program in s. 115.40, Stats., and the Collaborative Projects Program, in s. 115.28 (35), Stats., are two DPI grant programs which were created in the 1991-93 Budget Adjustment Act. The purpose of the programs is to promote collaboration among schools and public or private, nonprofit organizations in the delivery of educational and social services to pupils and their families.

Under the Collaborative Service Program, three-year grants are awarded jointly by the State Superintendent and the Secretary of Health and Social Services to eligible consortia of school districts, public agencies or private, nonprofit community-based organizations. The program grants are intended to promote greater access by pupils and families to community-based support services, such as health and mental health services, counseling, alcohol and other drug abuse prevention and intervention programs, extracurricular enrichment programs, before-school and after-school day care, tutoring, recreation, parent education and involvement activities and job training and placement. A collaborative service program may be designed to do one or more of the following:

(1) Improve communication and the sharing of information between the school district and local agencies;

(2) Design, implement and evaluate unified procedures to determine eligibility for various services;

(3) Provide staff development; or

(4) Provide pupils and their families with a variety of services at one location.

Beginning in the 1993-94 school year, grants totaling $324,999 general purpose revenue (GPR) were awarded to the Big Foot Area School Association ($37,440), the Eau Claire Area

School District ($69,804), the Kenosha Unified School District ($70,987), the Milwaukee Public Schools ($83,588), Montello and Westfield School Districts ($30,380) and the Tomahawk School District and Merrill Area Public Schools ($32,800).

Under the Collaborative Projects Grants Program grants of $100,000 GPR per year for a three-year period are awarded to each of three school districts (one rural, one suburban and one urban other than Milwaukee) for projects, conducted in collaboration with the county social services or human services department, that integrate social services and school responsibilities as they relate to pupils and their parents. The State Superintendent is required to give preference in awarding grants to projects that provide for the delivery of services in a single location.

Collaborative project grants are intended to promote greater involvement by parents, community representatives and county social and human services department personnel in developing programs to meet the health, social and educational needs of children.

Beginning in the 1993-94 school year, collaborative project grants were awarded to Hayward Community Schools, and to the Waukesha and Wauwatosa School Districts.

d. Consultant for School Nursing and Health Services

The DPI currently employs a full-time consultant for school nursing and health services. The school health consultant has the following responsibilities:

(1) Providing leadership and direct consultation to local education agencies, public health agencies and CESA's for the assessment, planning, implementation and evaluation of school nurse and school health programs;

(2) Providing liaison and leadership activities related to school nurse and health services within DPI and between DPI and local, state and federal health and education agencies;

(3) Collaborating with Wisconsin's collegiate nursing schools in the development of curriculum related to school nursing and the role of the nurse in the provision of school health services and comprehensive health education; and

(4) Providing DPI liaison and leadership activities with statewide and national level professional and voluntary organizations concerned with school nursing, school health services and comprehensive health education.

2. Department of Health and Social Services Programs and Activities

a. Comprehensive School Health Program Initiative

As discussed in item 4, a, above, the Wisconsin DHSS is currently participating in the Comprehensive School Health Program Initiative with the DPI. The DHSS project director for the Program is on the staff of the Bureau of Public Health in the Division of Health (DOH).

b. Maternal and Child Health Programs

The Section on Maternal and Child Health in the Bureau of Public Health, DOH, administers a maternal and child health (MCH) grant program with federal MCH block grant funds. One of six program categories funded is school age and adolescent health. Within that category, funds are provided to programs in the following areas: (1) comprehensive primary care services for school age children and adolescents; (2) comprehensive community-based adolescent health education; (3) interpersonal violence, including abuse, neglect and assault; (4) unintentional injury; (5) oral health: dental sealants; (6) oral health: school-based fluoride mouth rinsing; (7) oral health: dietary fluoride supplements; (8) optimal nutritional status for school age children and adolescents; and (9) Milwaukee Metropolitan Adolescent Pregnancy Prevention Consortium.

For federal fiscal year 1995, a total of $797,002 will be allocated to programs in the school age and adolescent health category. Not all of these programs actually operate in a school setting, but they all serve school age children. Staff at the DOH indicate that once final contracts are negotiated with each grantee by October 1, 1994, information will be available on the services to be performed in each program and the extent to which services will be provided in schools.

c. School Age Health Nursing Consultant

The DHSS has just hired a full-time school age health nursing consultant in the MCH Section of the DOH. The consultant works on policy development and provides technical assistance on issues relating to school age children. The consultant will be working closely with the public health nurse consultants at each of the DOH's five regional offices, as well as with the DHSS's project director for the Comprehensive School Health Program Initiative.

PART II

SCHOOL REQUIREMENTS

A. GENERAL REQUIREMENTS

1. State Constitution

Public schools in Wisconsin must meet a number of requirements and standards with regard to the provision of education and services, including the provision of school health services. The most basic requirement is found in art. X, s. 3, Wis. Const., which provides that the Legislature shall:

> Provide by law for the establishment of district schools which shall be nearly uniform as practicable; and such schools shall be free without charge for tuition for all children between the ages of 4 and 20 years....

2. Special Education: State and Federal

Schools must also provide special education services to children with exceptional educational needs under state law [subch. V, ch. 115, Stats.] and to children with disabilities under the Federal Individuals With Disabilities Education Act (IDEA) contained in 20 U.S.C. ch. 33. The purpose statement of IDEA reads as follows:

> It is the purpose of this chapter to assure that all children with disabilities have available to them...a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of children with disabilities and their parents or guardians are protected, to assist states and localities to provide for the education of all children with disabilities, and to assess and assure the effectiveness of efforts to educate children with disabilities. [See 20 U.S.C. s. 1400 (c).]

The federal law defines the term "children with disabilities" to mean children:

a. With mental retardation, hearing impairments, including deafness, speech or language impairments, visual impairments, including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments or specific learning disabilities; and

b. Who by reason of the disability need special education and related services.

The federal law defines "free appropriate public education" to mean special education and related services that:

a. Have been provided at public expense, under public supervision and direction, and without charge;

b. Meet the standards of the state educational agency;

c. Include an appropriate preschool, elementary or secondary school education in the state involved; and

d. Are provided in conformity with the individualized education program required under the law. [See 20 U.S.C. s. 1401 (a) (1) and (18).]

Federal law defines the term "related services" with respect to the requirements on school districts to include:

> ...transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, including therapeutic recreation and social work services, and medical and counseling services, including rehabilitation counseling except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children. [See 20 U.S.C. s. 1401 (a) (17).]

Wisconsin also has a special education statute which provides certain school district requirements. It should be noted that even if state law is modified or state requirements eliminated, federal law would continue to mandate the provision of special education services. Under state law, each school board must ensure that appropriate special education programs and related services are available to children with exceptional educational needs who have attained the age of three, who have not graduated from high school and who reside in the school district, or who reside in the state or county residential facility located in the school district and receives special education full- or part-time in the school district. [See s. 115.85 (1) (a), Stats.] Furthermore, each school board must ensure that, to the maximum extent appropriate, a child with exceptional educational needs is educated with children who do not have exceptional educational needs and that special classes, separate school and other removal from their regular educational environment occurs only when the nature or severity of the child's handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactory. The school board must also ensure that a continuum of alternative placements is available to meet the needs of children with exceptional educational needs. [See s. 115.85 (1) (a), Stats.]

State law defines a child with exceptional educational needs to include:

> ...a child with any of the following conditions, or such other conditions as the state superintendent determines, who may require educational services to supplement or replace regular education:
>
> (a) Orthopedic impairment.
>
> (b) Cognitive disability or other developmental disability.
>
> (c) Hearing handicap.
>
> (d) Visual handicap.
>
> (e) Speech or language handicap.
>
> (f) Emotional disturbance.
>
> (g) Learning disability.
>
> (h) Autism.
>
> (j) Traumatic brain injury.
>
> (L) Other health impairment.
>
> (m) Any combination of conditions named by the state superintendent or enumerated in pars. (a) to (L). [See s. 115.76 (3), Stats.]

State law defines "special education" to mean specially designed instruction at no cost to a child or the child's parents, to meet the unique needs of a child with exceptional educational needs, including all of the following:

a. Instruction in physical education; and

b. Instruction conducted in a classroom, at home, in hospitals and institutions or in any other setting. [See s. 115.76 (10), Stats.]

Table 1 illustrates the growth, in the last five years, of the number of children receiving special education services and the overall prevalence of special education in public and private elementary schools in Wisconsin.

TABLE 1

Special Education Pupils Enrolled in Public and Private Elementary and Secondary Schools in Wisconsin 1989-90 to 1993-94

	1989-90	1990-91	1991-92	1992-93	1993-94
Total Unduplicated Pupil Count	83,178	87,013	91,843	95,459	99,414
Total Public and Private Elementary and Secondary Enrollment	925,634	941,836	959,998	977,062	994,140
Overall "Prevalence"	8.99%	9.24%	9.56%	9.77%	10.00%

Source: DPI

As can be noted from the Table, the number of exceptional education students being served in Wisconsin has grown from 83,178 in 1989-90 to a 1993-94 level of 99,414. This is an increase of 19.5%.

3. Required Immunizations

The DHSS administers a statewide immunization program to eliminate mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough) and poliomyelitis, and protect against tetanus. [See s. 252.04 (1), Stats.] Schools are directly involved in monitoring compliance with this program.

Under the statutes, any student who is admitted to any elementary, middle, junior or senior high school or into any day care center or nursery school must, within 30 school days, present written evidence to the school, day care center or nursery school of having completed the first immunization for each vaccine required for the student's grade and being on schedule for the remainder of the basic and booster immunization series for the diseases enumerated above, or present a written waiver under the statutory provisions. [See s. 252.04 (2), Stats.] This immunization requirement is waived if the student, if an adult, or the student's parent, guardian or legal custodian submits a written statement to the school objecting to the immunization for reasons of health, religion or personal conviction. [See s. 252.04 (3), Stats.]

Under the statutes, by the 15th and 25th school day after the student is admitted to the school, day care center or nursery school, that school must notify in writing any adult student or the parent, guardian or legal custodian of any minor student who has not met the immunization or waiver requirements of the statute. [See s. 252.04 (5) (a), Stats.]

The statute permits a school, day care center or nursery school to exclude any student who fails to satisfy the first immunization requirements. However, no student may be excluded from public school for more than 10 consecutive school days, unless prior to the 11th consecutive school day of exclusion, the school board provides the student and the student's parent, guardian, or legal custodian with an additional notice, hearing and the opportunity to appeal the exclusion. A school, day care center or nursery school must notify the district attorney of the county in which the student resides of any minor student who fails to present written evidence of completed immunizations or a waiver within 60 school days after being admitted to the school. The statutes direct the district attorney to petition the court exercising jurisdiction under ch. 48, Stats. (Juvenile Code), for an order directing that the student be in compliance with the requirements of the immunization law. [See s. 252.04 (6), Stats.]

The statutes authorize the court to require an adult student or the parent, guardian or legal custodian of a minor student who refuses to submit a written waiver by the specified date to meet the terms of the immunization schedule to forfeit not more than $25 per day of violation.

The statutes require that DHSS must provide the vaccines under this program without charge, if federal or state funds are available for the vaccines, upon the request of a school district or local health department. Persons immunized may not be charged for vaccines that are furnished by the DHSS. [See s. 252.04 (8), Stats.]

The immunization program must be supervised by a physician selected by the school district or local health department. [See s. 252.04 (9) (a), Stats.] The DHSS is required to prescribe, by rule, the mechanisms for implementing and monitoring compliance with the program as well as prescribing the form that any person immunizing a student must provide to the student for reporting purposes. In addition, DHSS is required to submit a report to the Legislature on the success of the statewide immunization program on an annual basis.

The DHSS is given additional authority to enforce the requirement including the ability to exclude students without immunization if fewer than 98% of the students in the day care center, nursery school or school district are immunized. According to the DHSS, the statewide compliance rate with the immunization requirements has from its inception consistently been in the area of 94%-98%. For the most recent year, 1993-94, the compliance level was estimated to be 96.3%. Personal conviction waivers accounted for an additional 1.0% of the students in 1993-94.

Under s. 120.12 (16), Stats., school districts, in cooperation with local health departments, are required to develop and implement a plan to encourage compliance with the immunization statutes. This plan must be submitted to the DHSS by September 1 of each year. Further, schools must require each student to present evidence of completed basic and recall series immunizations or a written waiver under the statutes. [See s. 120.12 (16) (b), Stats.]

4. School District Standards: Emergency Nursing Services

The statutes set forth a number of school district standards which each school board must meet. Included in these standards is a requirement in s. 121.02 (1) (g), Stats., that each school board must provide for emergency nursing services. [This is often referred to as "**standard g**."]

The DPI has promulgated administrative rules to implement each of the school district standards. For "emergency nursing services," each school district board is required to provide emergency nursing services under a written policy adopted and implemented by the school district board which meets all of the following requirements:

a. The emergency nursing policies must be developed by a professional nurse or nurses registered in Wisconsin in cooperation with other school district personnel and representatives from community health agencies and services, as may be designated by the board.

b. Policies for emergency nursing services must include protocols for dealing with pupil accidental injury, illness and administration of medication at school sponsored activities including, but not limited to, curricular, co-curricular and extra-curricular activities and a method to record each incident of service provided.

c. Arrangements must be made with a licensed physician to serve as medical advisor for the emergency nursing services.

d. The nursing emergency services must be available during the regular school day and during all school-sponsored activities of pupils.

e. Pupil emergency information cards, equipment, supplies and space for the emergency nursing services must be appropriate and readily accessible.

f. A review and evaluation by the school board must be made of the emergency nursing services program at least annually. [See s. PI 8.01 (2) (g), Wis. Adm. Code.]

5. Authority of School Districts to Hire School Nurses

Under s. 120.13, Stats., school boards in counties having a population of less than 500,000 are authorized, to employ registered nurses, school nurses and public health nurses and licensed dentists who must be under the supervision of the local board of health and the DHSS. In counties having a population of 500,000 or more, the school board is authorized to employ qualified public health nurses, school nurses, registered nurses and licensed dentists who must cooperate with the local board of health and the DHSS.

The statutes define the term "school nurse" as a registered nurse licensed under ch. 441, Stats., who is also certified by the DPI as being qualified to perform professional nursing services in a public school. The State Superintendent is authorized to certify school nurses and make rules for the examination and certification of school nurses. [See s. 115.28 (7m), Stats.]

A school nurse is not required to hold a license issued by DPI. Under s. PI 3.51, Wis. Adm. Code, an applicant for a school nurse license must be a Registered Nurse (R.N.) in Wisconsin and meet the following requirements:

a. Completion of an approved doctorate degree program in school nursing which includes specified professional educational requirements in a school nursing practice for at least six-semester credits; or

b. Completion of a baccalaureate degree in nursing or a three-year nursing diploma earned prior to June 30, 1985 and be presently employed by or for a school board with completion of at least three years of experience in school nursing within the five years immediately preceding application for the license and have completed either the 12-semester credits required for professional education or be certified as a public health nurse and have completed at least six-semester credits from a list of specified subjects.

c. Completion of the following professional educational requirements:

(1) At least three semester credits in human growth and development throughout the life span.

(2) At least nine semester credits distributed among at least three of following areas:

(a) Sociology.

(b) Philosophy.

(c) Psychology.

(d) Special education.

(e) Other electives.

[See s. PI 3.51 (2) (b), Wis. Adm. Code.]

The administrative rule also recommends but does not require an emphasis on pediatrics and ambulatory care in community settings within the academic program.

The types of services provided by school nurses are described in Part III, B, of this Staff Brief.

In 1986, the DPI issued the Ad Hoc Study Committee Report on School Nursing in Wisconsin. This report was a product of a 14-member study committee involving more than a year of focus on a review of school nursing in Wisconsin. The Committee found a wide range in the extent of nursing and health services that were provided in Wisconsin's elementary and

secondary schools. This study noted that DPI certification standards for professional nurses are not mandated as they are for other professionals who practice in the public schools.

Based on these findings, the Committee made the following recommendations:

a. That legislative mandates be enacted for the provision of DPI-certified school nurse services to assure that the school-related health needs of all Wisconsin pupils are attended to during each school day.

b. That legislative mandates be enacted for the allocation of resources to assure that adequate health services managed by certified school nurses are funded for all school districts in Wisconsin.

c. That planning for the provision of school nurses and school health services be done cooperatively with students, parents, school district staff, community health service providers and local physicians and be based on documented school health needs.

d. That the school nurse be a functioning member of the professional pupil services team in the school organization structure.

e. That DPI develop information on the qualifications for school nurses and for a variety of school health service delivery models and disseminate them to local school boards, school administrators, health departments and Wisconsin collegiate schools of nursing.

f. That the school setting be recognized as one of the primary sites for support in collaboration with parents for early identification of health problems and for interventions to meet the school health needs of all school age children and youth.

g. That the statutes dealing with school board powers to hire nurses and dentists be revised or repealed to promote a collaborative relationship between school health personnel and local health departments.

h. That the DPI support the appointment of experienced nurses with master's degrees to school health leadership positions at the district, CESA and state department levels.

i. That the DPI collaborate with the Wisconsin DHSS in carrying out committee recommendations relating to organizational systems, certification, accountability measures and allocation of resources to provide necessary school health services in Wisconsin.

j. That the current school standard relating to emergency nursing services be modified to provide for school nurse services and that the provision of emergency services be included in the standard for the provision of a safe and healthful facility.

k. That a DPI school nurse advisory committee be appointed and funded to assist in accomplishing these recommendations and to assist in the process of obtaining mandatory school nurse certification.

Subsequently, DPI created a School Nurse Certification Rule Review Committee. That Committee, in a letter to State Superintendent John Benson dated June 17, 1994, made a series of recommendations for revising the administrative rules relating to school nurses. The Committee noted that because school nurses are neither currently mandated in local schools nor required to hold a DPI license, many Wisconsin schools do not hire nurses or contract for school nursing services. The Committee observed that without a health professional and pupil service teams, comprehensive planning efforts to promote health and prevent health problems for all students, their families and community cannot be effectively provided. Based on these observations, the Committee recommended that future entry into school nursing practice should be at the baccalaureate level and that DPI licensure should be mandatory for all nurses serving in Wisconsin public schools. The Committee recommended this requirement as an important first step in assuring the future development and delivery of comprehensive school health programs for Wisconsin children, their families and communities.

The Committee recommended that the requirements be phased in over a five-year period in order to allow adequate time for both institutions of higher learning and practicing nurses to plan for and begin to accommodate the recommendations. No formal action has been taken on the recommendations of this Committee.

6. Administration of Drugs to Pupils and Emergency Care [s. 118.29, Stats.]

Section 118.29, Stats., provides the authority for school boards to regulate the administration of drugs and also creates a civil liability exemption for the provision of emergency care. The statute provides that a school bus operator, any school employe or volunteer, county handicapped children's education board (CHCEB) employe or volunteer or CESA employe or volunteer who is authorized in writing by the administrator of the school district, the board or the agency, respectively, or by a school principal and any private school employe or volunteer authorized in writing by a private school administrator or private school principal:

a. May administer any drug which may lawfully be sold over the counter without a prescription to a pupil in compliance with the written instructions of the pupil's parent or guardian, if the pupil's parent or guardian consents in writing.

b. May administer a prescription drug to a pupil in compliance with written instructions of a practitioner if the pupil's parent or guardian consents in writing. ["Practitioner" is defined in the statutes in s. 118.29 (1) (e), Stats., to mean any physician, dentist or podiatrist licensed in this state.]

c. Is immune from civil liability for his or her acts or omissions in administering a drug or a prescription drug to a pupil under the statute, unless the act or omission constitutes a high degree of negligence. This statute specifically provides that this immunity provision does not apply to health care professionals. A "health care professional" is defined in s. 118.29 (1) (c), Stats., to mean a person licensed as an emergency medical technician or any person licensed, certified, permitted or registered under chs. 441 (nursing) or 446 to 449 (chiropractic, dentistry,

medical and optometry, respectively), Stats. The term "administer" with reference to drugs is defined in s. 118.29 (1) (a), Stats., to mean the direct application of a drug or prescription drug, whether by injection, ingestion or other means, to the human body.

The statute provides immunity for any administrator who authorizes any employe or volunteer to administer a drug or prescription drug to a pupil unless it is found to constitute a high degree of negligence.

The statutes also provide in s. 118.29 (3), Stats., that a person who is authorized to administer drugs, other than a health care professional, is immune from civil liability for his or her acts or omissions in rendering in good faith emergency care to a pupil of a public or private school. This immunity is in addition to and not in lieu of that provided under s. 895.48 (1), Stats.

The statute requires that any school board, CHCEB, CESA or governing body of a private school whose employes or volunteers may be authorized to administer drugs or prescription drugs to pupils must adopt a written policy governing the administration of drugs and prescriptions drugs to pupils. In developing this policy, the school board, board, agency or governing board is required to seek the assistance of one or more appropriate health care professionals who are employes of the school board, board, agency or governing body or are providing services or consultation under s. 121.02 (1) (g), Stats., the school standard relating to emergency nursing services.

This policy must include procedures for the following:

a. Obtaining and filing in the school or other appropriate facilities the written instructions and consent required by the statute.

b. The periodic review of such written instructions.

c. The storing of drugs and prescription drugs.

d. Recordkeeping.

e. The appropriate instruction of persons who may be authorized to administer drugs or prescription drugs to pupils under the statute.

The statute provides that no employe except a health care professional may be required to administer a drug or prescription drug to a pupil under the statute by any means other than ingestion.

7. Human Growth and Development Instruction

State statutes authorize, but do not require, a school board to provide an instructional program in human growth and development in grades kindergarten to 12. The purpose of the program is to encourage all school boards to make available to pupils instruction in topics

related to human growth and development in order to promote accurate and comprehensive knowledge in responsible decision-making as well as to support and enhance the efforts of parents to provide moral guidance to their children [s. 118.019 (1), Stats.]. If a school board decides to provide a program, then the program must offer information and instruction appropriate to each grade level and the age and level of maturity of the pupils. The program may include instruction in any of the following specified areas: (a) self-esteem, responsible decision-making and personal responsibility; (b) interpersonal relationships; (c) discouragement of adolescent sexual activity; (d) family life and skills required of a parent; (e) human sexuality, reproduction, contraception, including natural family planning, HIV and AIDS, prenatal development, childbirth, adoption, available prenatal and postnatal support and male responsibility; and (f) sex stereotypes and protective behavior. [See s. 118.09 (2), Stats.]

Further, each school board that provides an instructional program in human growth and development must annually provide the parents of each pupil enrolled in the school district with an outline of the curriculum used in the pupil's grade level and information regarding how the parent may inspect the complete curriculum and instructional materials. A school board must also make the complete human growth and development curriculum and all instructional materials available upon request for inspection at any time, including prior to their use in the classroom. [See s. 118.019 (3), Stats.] The statutes provide for an exemption by a provision stating that no pupil may be required to take instruction in human growth and development or in the specified subjects listed above, if the pupil's parent files with the teacher or school principal a written request that the pupil be exempted. [See s. 118.019 (4), Stats.] Each school board must also appoint an advisory committee and permit that committee to develop a human growth and development curriculum and advise the school board on the design, review and implementation of the advisory committee's human growth and development curriculum. In addition, the statute requires that the advisory committee review the curriculum at least every three years and file a written report with the DPI indicating that it has done the review. [See s. 118.019 (5), Stats.]

The statutes authorize DPI to award grants to do any of the following: (a) to a school board, to assist the board in developing or improving a human growth and development curriculum; and (b) to a CESA, to enable the agency to provide technical assistance to a school board to develop or improve a human growth and development curriculum. However, the Department is prohibited from awarding a grant unless the school board receiving a grant or being assisted by a CESA receiving a grant first agrees to include instructions in all of the areas specified above.

The Legislature authorized $200,000 GPR in each fiscal year 1993-94 and 1994-95 for grants for human growth and development instruction. In addition, state aids of $25,600 are paid to each of the 12 CESA's to assist school districts with human growth and development programs.

PART III

GENERAL SCHOOL HEALTH DELIVERY MODELS AND SERVICE DELIVERY IN WISCONSIN

This Part of the Staff Brief briefly describes a variety of models for providing school health services utilized around the country and then describes the manner in which school health services are delivered in Wisconsin and the types of services delivered.

A. GENERAL MODELS OF DELIVERING SCHOOL HEALTH SERVICES

In a March 1994 report, Special Report: Defining School-Based Health Center Services, staff of the School Health Policy Initiative of Columbia University's School of Public Health outlined six general models of delivering school health services which are utilized around the country. They are as follows:

1. **School-based screening, referral and follow-up services.** These services are the traditional "school nurse" services, typically provided either by a school nurse hired by a school district or by a nurse from another agency such as a local health department. They include such services as routine first aid, vision and hearing screenings, health assessments, immunizations, health education and referrals for other care.

2. **School-based health clinics.** These are facilities located on school grounds which usually provide a comprehensive array of health-related services to students. These services may be limited to medical services or may also include social services and mental health services. The range of services varies depending on the particular clinic and may include such services as physical examinations and developmental assessments; laboratory tests; diagnosis and treatment of minor, acute and chronic problems; family planning services or referrals; health promotion and prevention; immunization; nutrition counseling; dental health assessment and referral; substance abuse assessment and referral; HIV/AIDS education and counseling or referral; and mental health and social services assessment, treatment or referral.

3. **School-linked clinics with comprehensive services.** These clinics generally provide the same range of comprehensive medical services and, in some cases, social or mental health services as school-based clinics do, but in an off-school grounds setting, operated in cooperation with the school.

4. **School-linked clinics limited to family planning and mental health services.** These are school-linked clinics which do not provide a comprehensive range of services but rather are designed to provide confidential and convenient reproductive health care and counseling services.

5. **Services integration on-site.** This model involves having medical, mental health and social services agencies co-located in a school setting, with multiagency collaboration and

the coordination of multiple services and funding sources. Services may include education, public health, social support, child care, housing, transportation, juvenile justice, employment training, preventive health care and primary care. School-based health centers are one means of delivering services in this model.

6. **Services integration by referral.** This model utilizes a coordinated referral system located on school grounds which is designed to link students and their families with a range of community social and health services which are themselves located off-school grounds.

Of the six models, the school-based clinic model appears to be the most thoroughly studied, likely as a result of the establishment in 1986 of the School-Based Adolescent Health Care Program by the Robert Wood Johnson Foundation. Through the Foundation, 18 grantees were selected to receive start-up funds to develop school-based health centers and operating funds to administer the centers. An evaluation of the Program by the Mathtech Company noted that the Foundation's experiment with school-based health centers showed the centers to be an effective way to offer a comprehensive set of services to adolescents at a place they frequent. A May 1994 report on school-based health centers by the General Accounting Office concluded that the centers improved children's access to health care.

B. SCHOOL HEALTH SERVICE DELIVERY IN WISCONSIN

In Wisconsin, the first two models described above are employed for delivery of school health services. They include: (1) utilization of school nurses who are either employed by school districts or other agencies such as local health departments to provide school nursing services; and (2) school-based clinics. Also, the collaborative programs described in Part I, B, 1, c, above, incorporate elements of the sixth model, services integration by referral.

1. Methods of Providing Nursing Services in Schools

According to DPI, 399 of the 427 public school districts in Wisconsin report affiliation with an R.N. who provides school nursing services. Of those 399 school districts, 264 (66.2%) report hiring their own school nurses for varying hours of work per week, while 135 (33.8%) report contracting or entering into memoranda of understanding (MOA's) with local health departments or other agencies for school nursing services.

There are a number of possible arrangements between school districts and local health departments to provide school nursing services and a greatly varying range of services are provided around the state, depending on the particular school district and health department. Some local health departments view it as part of their job to provide a certain amount of nursing services to children in a school setting. These departments may enter into a contract or MOA with a school district to provide certain nursing services, such as vision and hearing screenings and checking for currency of immunizations, without charge to the district. Other local health departments do not offer any free screening services in schools but enter into a contract or MOA with a district to provide those or more extensive nursing services and receive reimbursement from the school district for those services.

Some school districts contract or enter into MOA's with other entities such as home health agencies, hospitals or health clinics to provide school nursing services. Some districts that employ some of their own school nurses may also utilize nurses from local health departments or these other entities to provide certain services. Thus, some of the 264 school districts which report that they hire school nurses may also enter into arrangements with either local health departments or other agencies for additional nursing services.

The DPI does not maintain detailed data on the various school nursing arrangements utilized by school districts, such as the number of districts that use both school district-employed nurses and local health department or other agency nurses, the number of hours per week that individual nurses provide school nursing services and the particular services provided in each district. Information on total reported expenditures by school districts is contained in Part IV, at page 33 of the Staff Brief.

a. School Nursing Mission and Potential Array of Services

(1) DPI Perspective on School Nursing Services

In an effort to describe the mission of school nursing services and the potential array of services, the DPI has issued an Information Sheet, School Nursing/School Health Services in Wisconsin, dated January 1994. The Information Sheet describes the mission of school health services as being to enhance the individual abilities of children and youth to use their intellectual potential for learning, including their ability to make decisions that support their present and future physical, social and emotional health by means of individual, group and environmental interventions. The Information Sheet sets forth the three traditional elements of school health as: (a) health education; (b) health services; and (c) a healthful school environment, and notes that the concept of comprehensive school health expands those traditional elements to also include child nutrition services; physical education; school guidance and counseling; social work and psychological services; employe health promotion/wellness; parent and community involvement; and multidisciplinary curricular instruction.

The Information Sheet states that there is great disparity among Wisconsin's elementary and secondary schools in the school health services currently provided, both in terms of the range of services provided, the persons providing the services and the number of hours per week the services are available. The Information Sheet then goes on to list the following health services which may be delivered in schools.

A. Direct Services to Pupils and Staff

1. Acute care.

   a. Provide first-aid.

   b. Manage and provide care for pupils with acute and episodic illnesses.

2. Health maintenance.

   a. Supervise and teach self-care.

   b. Supervise the administration of medications and special diets.

   c. Supervise and provide physical care procedures.

   d. Provide immunizations.

   e. Coordinate referral to community resources.

   f. Identify and isolate students with communicable diseases.

   g. Provide employe health services.

   h. Coordinate and provide care for students with chronic illnesses.

B. Health Counseling for Individuals and Groups

1. Promotion.

   a. Provide child advocacy services.

   b. Teach prenatal classes for childbearing students.

   c. Provide family change counseling.

   d. Provide mental health counseling.

   e. Provide and clarify health information.

   f. Provide family planning counseling.

   g. Provide health risk counseling.

   h. Provide parenting classes.

   i. Teach nutrition classes.

2. Intervention.

   a. Provide crisis intervention.

   b. Provide and coordinate individualized plans of care.

c. Facilitate collaboration between pupils, parents, professionals and community resources.

C. Identification and Follow-Up of Health Problems

1. Assessments.

   a. Organize, provide and supervise screening programs for vision, hearing, height, weight, hypertension, scoliosis, dental and nutrition.

   b. Obtain health and developmental history of individuals/family.

   c. Perform physical assessments.

   d. Identify health problems that impact on learning.

   e. Identify pupils who are not receiving regular health care.

   f. Identify pupils with health problems who are not receiving appropriate treatment.

2. Follow-up.

   a. Develop health criteria for individualized education programs.

   b. Refer to appropriate community resources.

   c. Provide health care needed to enable students to attend school and benefit from the learning experience.

   d. Refer to appropriate medical and health care.

D. Health Education

1. Personal health.

2. Mental and emotional health.

3. Prevention and control of disease.

4. Nutrition.

5. Substance use and abuse.

6. Accident prevention and safety.

7. Community health.

8. Consumer health.

9. Environmental health.

10. Family life education.

E. Program Management

1. Supervision.

    a. Establish program priorities.

    b. Set up referral systems.

2. Policy and procedure development.

    a. Administration of medications.

    b. Access to records.

    c. Identification and referral of child abuse and neglect cases.

    d. Identification and referral of alcohol and drug abuse cases.

    e. Screening procedures.

    f. Health-related absentee follow-up procedures.

    g. Emergency care procedures.

3. Staff development.

4. Resource management.

    a. Provide adequate physical facilities and supplies.

    b. Provide adequate support personnel.

F. Data Management

1. Record maintenance.

    a. Accident reports/insurance reports.

    b. Emergency care log.

c. Individualized school health records:

(1) Basic health status database including immunizations;

(2) Documentation of nurse diagnosis and treatment; and

(3) Health screening results and follow-up.

2. Evaluations.

a. Provide summaries for program planning.

b. Assure follow-up of individual health problems.

(2) Local Health Department Perspective on School Nursing Services

According to data from the DHSS's Center for Health Statistics, local health departments provide a number of specialized health services in school settings. These services include screenings for certain medical conditions and diseases, individual health conferences and treatments and procedures for students with special health needs. In a draft report, Wisconsin Local Health Department Utilization 1993 (expected publication date October 1994), the Center for Health Statistics states that 70 local health departments reported performing a total of nearly 215,000 student vision screenings and 71 departments reported performing over 133,000 hearing screenings in 1993. In addition, 48 departments indicated that they performed screenings for scoliosis (a condition of the spine) while 31 departments performed "other" screening services, such as hypertension screening and health risk assessment. Most vision, hearing and "other" screenings were performed in elementary schools; scoliosis screenings were generally performed in middle and junior high schools. School health screenings sometimes resulted in referrals to medical providers for further evaluation and, in certain cases, recommendations for treatment.

According to the draft report, local health departments also provided school health services other than student screenings. Forty-six departments reported that they conducted individual health conferences or face-to-face discussions with students, parents and school employes regarding specific health problems, over half of which occurred at the elementary school level. In addition, 37 departments stated that they provided school-based services under the general category of "health treatments and procedures." These services included providing first aid as well as special care for students with serious medical conditions such as cerebral palsy and cystic fibrosis. Forty departments provided other, unspecified school health services such as employe blood pressure screening, most often in elementary schools.

b. School-Based Clinics

Two Wisconsin high schools, both in the Milwaukee public school system, have school-based health clinics on their premises. North Division High School's clinic is known as the Teen Education and Comprehensive Health (TEACH) Clinic and is affiliated with the Isaac Coggs Health Connection, Inc., a community health center in Milwaukee. According to a

brochure about the TEACH Clinic, its purposes are to encourage responsible health practices and to provide health care accessibility for students at North Division High School. The TEACH Clinic operates during school hours every day with a receptionist, a medical assistant, a certified nurse practitioner and a physician who is available for certain of those hours and days. The Clinic provides a number of health care services, including treatment for acute minor illnesses and chronic illnesses, as well as preventive health services, such as physicals and sports examinations, scoliosis and hearing screenings, and a number of reproductive health care services, such as gynecological examinations and Pap smears. In addition, the Clinic provides immunizations, a range of laboratory services, individual and family counseling and education about nutrition and other health-related issues. The Clinic brochure states that no medication or contraceptives are dispensed at the TEACH Clinic and that no abortion counseling is provided.

The TEACH Clinic currently receives most of its funds from transitional funding received by the Isaac Coggs Health Connection, Inc., from the Bureau of Public Health in DHSS. In addition, some funds are provided by the State Medical Assistance (MA) Program through the MA/HMO (health maintenance organization) program in Milwaukee for prenatal care services. Some uncompensated care is provided to clinic patients by Sinai-Samaritan and Columbia Hospitals and some physician time is provided by the Medical College of Wisconsin through the St. Mary's Hospital Family Practice Program.

South Division High School's clinic is known as the Wellness Center. It is affiliated with the Sixteenth Street Community Health Center in Milwaukee. The Wellness Center offers a similarly comprehensive array of health prevention, treatment, education and counseling services as does the TEACH Clinic. The Wellness Center operates during school hours with a receptionist, a medical assistant, a physician's assistant who serves as clinic manager and a rotating physician from the Sixteenth Street Community Health Center. The Wellness Center is funded by a combination of private foundation funds and reserve funds from the Sixteenth Street Community Health Center. The brochure for the Wellness Center indicates that no birth control pills or devices are dispensed or prescribed and no abortion counseling or referrals are provided.

PART IV

FUNDING OF SCHOOL HEALTH SERVICES

A. GENERAL

As noted in Part II, pursuant to the provisions of art. X, s. 3, of the Wisconsin Constitution, the Legislature is responsible for the establishment of public school districts which are to be as nearly uniform as practicable and free and without charge for tuition to all children. Funding for schools is derived primarily from local property taxes and state aids with some support from federal sources. The state aids are financed primarily by general purpose taxes, income and sales tax. Wisconsin provides financial assistance to the 427 school districts to achieve two basic policy goals: (1) reduce the reliance on the local property tax as a source of revenue for educational programs; and (2) guarantee that a basic educational opportunity is available to all pupils regardless of the local fiscal capacity of the district in which they reside.

The cost of elementary and secondary education in general is supported by the state through three different methods. First, unrestricted general aids are provided through a formula that distributes aid on the basis of the relative fiscal capacity of each school district (as measured by the district's per pupil value of taxable property). This formula is known as either the general school aid formula or the general equalization formula. In addition, the Legislature has established several other general aid programs which are, in varying degrees, related to or affected by the equalization formula.

The second method of state support is categorical aids which partially fund specific program costs (such as handicap education, pupil transportation, school lunches and driver education). Categorical aid is either paid on a formula basis or awarded as grants.

The third method of state support is the state's property tax credit program, the school levy credit and the lottery credit programs.

It is possible that district costs for school health services may be supported through local, state and federal funds. With regard to state funds, the money may be distributed to the school district or service provider such as a CHCEB or CESA through the general aid or a categorical aid program. Unfortunately, at this time, data is not available on the level of expenditures by local school districts or the source of reimbursement for those services.

Generally, if a district is eligible for state equalization aid, a district is reimbursed through the equalization formula for a portion of its shared costs which can include costs incurred for providing nursing and other medical services. In addition, a district may also be eligible for categorical aid under the handicapped aid program. Under this program, the state reimburses school districts, CESA's and CHCEB's for a portion of their prior year costs for educating and transporting pupils enrolled in special education. The reimbursement is based on a fixed percentage of cost, regardless of the total amount expended or the property tax base of

the district, as follows: (1) 63% of the salaries and fringe benefit costs for special education teachers, physical and occupational therapists, teacher and therapy aides and program supervisors and coordinators; (2) 63% of the cost of transportation for pupils enrolled in special education programs; (3) 51% of the salaries and fringe benefit costs for senior level school psychologists and social workers, regardless of whether they are employed in special education programs; and (4) 100% of the cost of board, lodging and transportation of nonresident children enrolled in a district special education program. However, due to a limit on the amount of funds available, the statutory rates have typically not been fully funded, and a proration of the total amount has been paid instead, based on the amount of funds available. The last time the rates were fully funded was in 1984-85. Any cost not reimbursed through categorical aid is eligible for state sharing under the general equalization formula.

Other health-related categorical aid programs include grants administered by DPI to address the problem of alcohol and other drug abuse (AODA) among school age children. State grants have also been provided as a categorical aid to supplement the Federal Head Start Program which provides comprehensive educational, health, nutritional, mental health and social services to low-income and disabled preschool children and their families.

It has become increasingly difficult for school districts to provide related special education services to assist and maintain students in their special education programs within their home communities. It is anticipated that the growth in the number of students requiring these services will continue to increase because of the following factors: (1) more children who are medically fragile are surviving infancy; (2) more children with identified exceptional education needs are deinstitutionalized; (3) more infants are born with neurological problems due to drug/alcohol abuse, AIDS and similar problems; (4) the severity of children's problems has increased, with the resultant increase in intervention time; (5) more special education children with medical problems are integrated into regular education and require related services to enable them to function in the least restrictive environment; and (6) increasing numbers of young children ages zero to three with related service needs will be attending early intervention programs.

As the needs for these services has increased, so has the cost. A February 1990 report, entitled An Evaluation of Handicapped Education Programs, prepared by the Wisconsin Legislative Audit Bureau (LAB), found that expenditures for occupational and physical therapy which were included in the cost of instruction, increased more than 53% from 1984 to 1987-88. While the LAB attributed some of this increase to an increasing demand for services, the Bureau noted that the majority of the increases were due to the increasing costs of the services themselves.

Local school district expenditures for health-related services, excluding special education, have also increased substantially in recent years, as is demonstrated in Table 2.

The totals reflect the amounts school districts have expended on physical and mental health services which are not direct instruction, including activities that provide students with appropriate medical, dental and nursing services. The figures, as reported annually to the DPI,

also include amounts spent for health appraisal, including screening for vision, communicable diseases and hearing deficiencies; screening for psychiatric services; periodic health examinations; emergency injury and illness care; and communications with parents and medical officials.

TABLE 2
Total School District Expenditures for School Health-Related Services

Year	Total Expenditure	Amount of Change	Percentage Change
1991-92 Actual	$ 9,656,762		
1992-93 Actual	$10,922,328	+$1,265,566	+13.1%
1993-94 Budgeted	$12,974,229	+$2,051,901	+18.8%

Source: DPI

These increasing costs have prompted schools to seek other sources of support. The next section describes efforts to cover some health-related costs through public and private insurance providers.

B. PUBLIC AND PRIVATE INSURANCE

When the original Education of the Handicap Act (EHA), P.L. 94-142 and the related regulations, passed with language requiring individualized education programs and required special education and related services, Congress failed to clarify whether the requirements extended to all fiscal responsibilities as well as all implementation responsibilities. As a result of this lack of clarity, many noneducational state agencies interpreted the requirement of a "free and appropriate education" to mean that any services appearing on a special education student's individualized education plan (IEP) were the specific fiscal responsibility of the school district. Education agencies were told initially they would receive federal dollars to help offset the costs associated with compliance. However, the federal government has never met its obligation to provide an appropriate funding level for this legislation.

Congress, in P.L. 99-457, Education of the Handicap Act Amendments of 1986, addressed the issue of fiscal responsibilities. These Amendments were adopted to ensure that state and local education agencies would not be required to bear all the financial burden for services covered by other entities prior to the enactment of P.L. 94-142. To this end, P.L. 99-457 describes education agencies as the "payer of last resort." The law gives states a clear directive to use all possible funding sources for required programs before utilizing federal dollars, stating that other sources may include private insurance as well as state health agencies. As noted above, the public school system must ensure that all identified special education students have access to a free and appropriate education. Those students who receive special education-related services, therefore, must have access to those services at no extra costs to their families. Thus, families must be assured they are at no extra risk for loss of property or benefits.

Another law addressing a similar concern was the Medicare Catastrophic Coverage Act [P.L. 100-360], which became effective on July 1, 1988. Although the main thrust of this legislation was revision of the Medicare program, it also contained a significant amendment to the Social Security Act relating to the financing of "related services" included in a student's IEP or in an individualized family service plan (IFSP). The amendment provided that Medicaid could not use the fact of services being required by a child's IEP or IFSP to restrict or prohibit reimbursement for those services.

These changes in the federal law opened the possibility of obtaining support from the health care system; specifically, from public and private insurance providers. The health care financing system consists of individuals, groups of individuals or organizations categorized as follows: (1) the patient or "first party"; (2) the service provider or "second party"; and (3) an insurance entity or "third party." Typically, a contractual relationship is established between the patient and provider when the patient asks the provider to perform services in exchange for the patient's consent to promptly pay the provider a customary fee for the services performed. The third party in this arrangement has no binding interest in the patient-provider contract; the third party's contractual relationship is with the insured patient. An exception to this patient-provider rule concerns the provider's relationship when treating Wisconsin Medical Assistance Program (WMAP) recipients. [It should be noted that "Medicaid" is the term used to refer to the federal program; "Medical Assistance" is the term used to refer to the program in Wisconsin.] Federal law, as noted above, clarifies that Medical Assistance (MA) agencies are financially responsible for any covered, medically necessary services which are included in the IEP of a handicap child who is an MA recipient. Services such as speech pathology, occupational therapy and physical therapy are examples of covered therapy services that may be identified in a child's IEP.

Whether or not services in a student's IEP are covered by WMAP is determined by the DHSS's Bureau of Health Care Financing in accordance with related statutes, rules and policy guidelines. There are four prerequisites to coverage, as follows: (1) the student must be eligible for WMAP on the date of service; (2) the services must be rendered by a provider certified by WMAP for the date of service; (3) the services must be medically necessary, in other words, all therapy and other professional services not performed by a physician must be prescribed by a physician; and (4) the services must be provided in accordance with WMAP guidelines.

The WMAP provides insurance coverage for medical and rehabilitative services. The federal government reimburses Wisconsin for a portion of the benefits made available by WMAP. Within federal guidelines, the individual states can offer a varying array of services under their MA plans.

There are presently efforts underway to increase the capacity of school districts to utilize Medicaid resources. Currently, however, no school district in Wisconsin is systematically receiving Medicaid reimbursement for the provision of school health services. Several other states, including Missouri, have recently passed legislation to encourage school districts to seek Medicaid reimbursement.

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EXECUTIVE SUMMARY FROM 1993 WISCONSIN YOUTH RISK BEHAVIOR SURVEY

What are the risks to the health and safety of Wisconsin's youth? How can state leaders learn about and mobilize to meet the health and safety needs of its school-age children? To determine the answers to these questions, every two years since 1989 the Wisconsin Department of Public Instruction (DPI) has surveyed students. In 1993 the DPI and the U.S. Centers for Disease Control (CDC) joined forces to conduct the Youth Risk Behavior Survey. The 99 questions in the survey instrument were designed to measure objectives set by the CDC as part of its Year 2000 initiative.

The CDC defined 16 objectives regarding the health of American youth. The objectives address five areas of concern: intentional and unintentional injuries; the use of tobacco, alcohol, and other drugs; sexual activity; dietary patterns; and physical activity. The survey instrument, objectives and rationale are provided in the full report of survey results.

Nearly 6,000 students in grades six, eight, and nine through twelve participated. Details about the sampling and analysis are included in the full report. The weighted responses can be used to make important inferences concerning the priority health-risk behaviors of all Wisconsin public school students at each level.

Where data were available, Wisconsin rates are compared to national rates. However, the latest national data available were collected in 1991. Readers should consider the differing time periods when comparing data.

Injuries

Objectives and questions addressing intentional and unintentional injuries deal with behaviors involving vehicles, weapons, physical aggression, and suicide.

Wearing seat belts and helmets are two safety measures that can prevent injuries involving motor vehicles. But, according to their responses, fewer than 50 percent of Wisconsin students always used seat belts and only 45 percent of the motorcyclists and 1 percent of the bicyclists always wore a helmet.

Students are carrying weapons (nearly one of five) and they are carrying them on school property (nearly one of ten). However, the 9 percent of Wisconsin students who carry weapons to school is well below the national average of 26 percent. In Wisconsin, the most commonly carried weapon among students is a gun, and the 16 percent of Wisconsin male students who carry guns is higher than the national average of 12 percent.

Four of ten students reported engaging in a physical fight, 40 percent of the time on school property. The 16 percent of Wisconsin students who reported fighting on school property is well below the national average of 42 percent.

Nearly one of three students (27 percent) reportedly considered suicide and one in five (22 percent) planned how to do it.

Tobacco, Alcohol, and Other Drug Abuse

The objectives and questions about drug use address, respectively, tobacco; alcohol; other drugs; factors in the home, school, and social environment; and the role of drugs in other activities involving risks, such as driving and sexual intercourse.

Tobacco use among students in grades eight, ten, and twelve has increased since 1991. Seven of ten students have smoked a cigarette at least once. Three of ten reported having smoked during the past 30 days. An equal number reported being regular smokers. One in eight students reported having used smokeless tobacco.

The data about alcohol use were more encouraging. Data from all grade levels showed a decrease in use from 1991 to 1993. The greatest decrease was at the sixth grade level, at which use dropped from 55 percent to 33 percent. Still, four of five students said they had at least one drink of alcohol in their lifetime. Half reported having had an alcoholic drink in the past 30 days. One third of the students responding to the study qualified as "binge" drinkers (having consumed five or more drinks of alcohol in a row in the past 30 days).

Survey questions about illicit drugs measured the use of marijuana, cocaine and crack cocaine, inhalants, steroids, and other drugs. Students were asked if they ever used and if they used during the previous 30 days. Fourteen percent of students had used some form of illicit drug other than marijuana or cocaine. One of four students reported having tried marijuana, one of ten in the past 30 days. Fewer than five of 100 students have ever used any form of cocaine in their lifetime, three of 100 in the past 30 days. One in five students reported having used an inhalant to get high. Five in 100 reported using steroids.

Comparisons show fewer students in grades ten and twelve have tried marijuana than at those grade levels in 1991. The rate for grades six and eight remained the same. The percent of students who tried cocaine also decreased except for grade eight. The four percent of eighth-graders who reported having tried cocaine in 1993 compare to 2 percent in 1991. Similarly, the 4 percent of eighth-graders and 3 percent of tenth-graders who reported having tried crack cocaine in 1993 compare to 2 percent each in 1991. The rates for grades six and twelve remained the same.

Perhaps the riskiest behavior among young students and adults is drinking while driving or driving with someone who is under the influence of alcohol. Fifteen percent of students reported having driven a vehicle once or more in the past 30 days after they had been drinking alcohol. Forty percent of students reported riding with someone who had been drinking.

Sexual Behaviors

The objectives and questions about sexual behaviors address HIV/AIDS, sexual intercourse, other sexually transmitted diseases (STDs), unintended pregnancies, and forced sexual activity.

Questions about HIV/AIDS asked if students had received instruction about HIV/AIDS and if they had discussed the information with a parent or other adult in their family. Eighty-four percent reported having received information in school. Only 58 percent, however, had discussed the information with a parent or other adult.

Nearly one in two Wisconsin students reported having had sexual intercourse at least once. Six percent reported having been told by a medical professional that they had contracted an STD. Of the sexually active students, 58 percent used a condom during last intercourse and 22 percent reported using birth control pills. Five percent of students said they have been pregnant or gotten someone pregnant one or more times.

A disturbing occurrence in the behavior of high school youths is coercive sexual activity. Thirteen percent said they had been verbally or physically

forced to take part in sexual activity. Nearly 4 percent of students said they had physically or verbally forced someone into sexual activity.

Dietary Patterns

The objectives and questions dealing with dietary patterns address weight and dietary fat intake. Questions about weight addressed students' satisfaction with their weight and efforts to control their weight.

Forty-four percent of students regarded themselves as being "about the right weight." Thirty-six percent considered themselves overweight while 20 percent felt they were underweight. Satisfaction with weight varied according to gender and race. Nearly half of the students (43 percent) were trying to lose weight. The most popular weight control method was exercising.

Questions about food intake asked how often, during the previous day, students had eaten two types of food: fruits and vegetables, and high-fat foods. The high-fat foods measured were fatty meats, fried foods, and fatty carbohydrates. Many diets were missing fruits and vegetables: 36 percent no fruit, 38 percent no fruit juice, 72 percent no green salad, and 55 percent no cooked vegetables. Fatty foods were more popular: 52 percent had eaten a hamburger, hot dog or sausage; 53 percent french fries or potato chips; and 65 percent cookies, doughnuts, pie, or cake.

Physical Activity

The objective and questions addressing the physical activity of U.S. youth address the type, frequency, duration, and source of physical activity over the past seven days and the past 12 months. Types of exercise were aerobic, stretching, and strengthening or toning. Sources were walking or bicycling, physical education classes, school sports teams, and other sports teams.

Exercise was missing from the lives of many students: 15 percent reported no aerobic exercise, 27 percent no stretching exercise, and 29 percent no strengthening or toning. Sources of exercise were walking or bicycling (53 percent), physical education class (68 percent), school sports teams (56 percent), and nonschool sports teams (42 percent).

Overall, the level of physical activity by Wisconsin students is lower than the national average, with two exceptions: Wisconsin students in grade eleven reported more stretching, and Wisconsin students in grades eleven and twelve reportedly attended physical education class more often. The responses from youth are consistent with studies of adult populations, which suggest that, compared to national averages, Wisconsin residents have higher levels of obesity and lower levels of physical activity.

Conclusions

What does all the information say? For starters, it provides a snapshot of the risks to the health and safety of Wisconsin youth. Secondly, for the questions studied in previous surveys, the 1993 data allows us to measure change and, to some extent, the success of our efforts to promote healthy behaviors.

Three changes are encouraging. The decrease in the use of drugs other than tobacco, whatever the reason for the decrease, represents success. So does the reduction in drinking and driving and the delay in the age at which students first use alcohol, which research says is an important factor in reducing alcohol-related problems in later life.

Those successes will provide momentum as we address needs revealed by the survey results. While the snapshot provided by the results confirms the dangers students face, it also shows that students don't take advantage of many precautionary methods available to them. Their behaviors regarding seat belts, helmets, drinking and driving, and condoms support the contention that young people feel they are indestructible and immortal. Those behaviors indicate the following needs.

- Increase the use of seat belts and helmets.
- Reduce the number of students who carry weapons and who engage in fighting.
- Reduce the use of tobacco.
- Increase the number of students who protect themselves against sexually transmitted diseases.
- Increase the number of students who eat properly and exercise.

The increase in tobacco use is upsetting because of the incidence of illness and deaths due to smoking and because of the belief that a person passes through the "gateway" to illicit drugs when becoming a smoker.

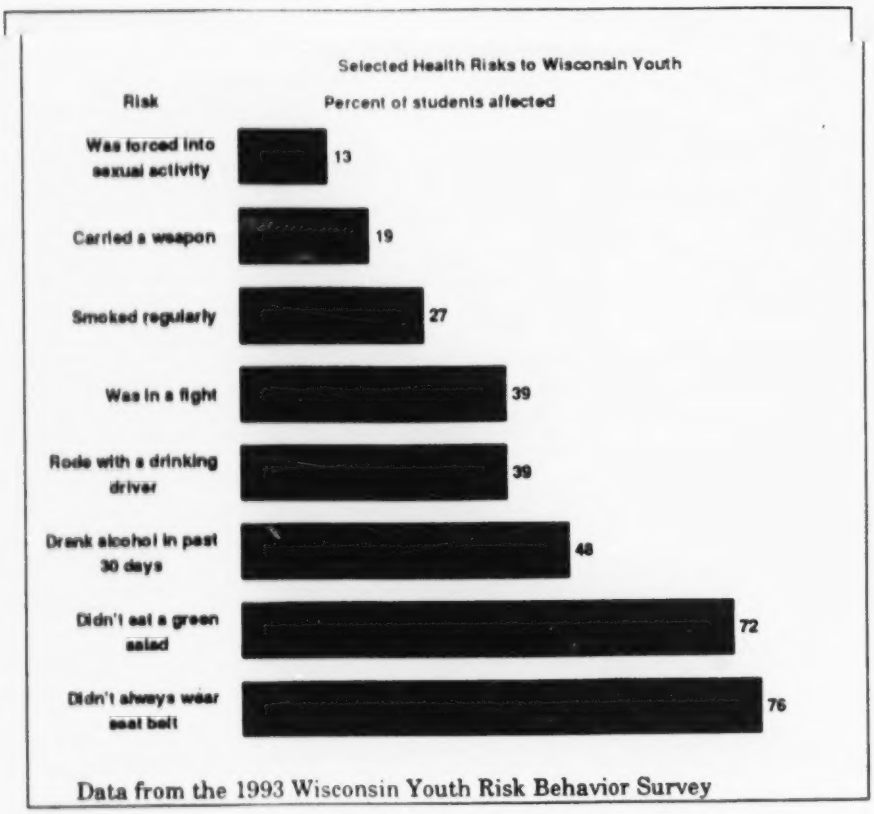
Although health professionals might disagree about which—proper nutrition or exercise—is more essential to having a healthy body, no doubt all would agree that Wisconsin students need to improve in both areas.

In addition to identifying risky behaviors, the survey results point to ways various individuals and groups might be able to promote improvement. For example, nine of ten students said their parents would be "very upset" to learn their child used an illicit drug other than alcohol; only one in four tried marijuana and four in 100 tried cocaine. On the other hand, two of five students said their parents would be only "a little upset" or "not at all upset" if the child used alcohol; four of five students had used alcohol. (Wisconsin parents contacted in a 1992 survey did indeed find the use of illicit drugs to be far more intolerable than drinking. Their responses were reported by the DPI in 1993 in *A Tradition of Tolerance: What Wisconsin Parents Think About Teen Alcohol Use.*) Society, beginning with parents, seemingly could be very influential in further reducing the number of students who use alcohol.

The survey results also point to the need for additional research. For instance, we need to learn more about Wisconsin students' concerns and behaviors involving their weight. The 1993 survey did provide facts where a misconception existed. Data about eating disorders indicates that, at least in Wisconsin, eating disorders are not confined to female students. Responses to the survey showed no substantial differences between male and female students regarding the use of vomiting or diet pills for weight control. We still don't know, however, *why* a substantial number of students (60 percent of the female students) are trying to lose weight. While weight loss can promote health when designed to improve nutrition and fitness or to resolve a valid weight problem, it's a risky behavior if motivated by a distorted body image, a culturally influenced desire to be overly thin, or is symptomatic of an eating disorder.

The data about weight control methods also point to a need for additional research. While 80 percent of female students reported attempts to either lose or maintain weight, only 67 percent reported using a method mentioned in the survey.

We must set about finding solutions to the needs revealed by the 1993 survey so the snapshot of students who respond to the 1995 survey will show a healthier group.



Data from the 1993 Wisconsin Youth Risk Behavior Survey